



Commonwealth of Massachusetts, Department of Public Health, Division of Food and Drugs
305 South Street, Jamaica Plain, MA 02130
Telephone 617 983-6700 Fax 617 524-8062

Application for Massachusetts Controlled Substances Registration for Optometrists
In Accordance with the Controlled Substances Act, M.G.L. Chapter 94C

Please be sure to:

- Complete the application form
- Enclose check or money order for \$150 made payable to "Commonwealth of Massachusetts"
- No fee is charged if submitting this form only for *Amended Information*
- Enclose a photocopy of your current Board of Registration license
- Sign and date the form at the bottom
- Mail to the address above

Incomplete applications will be returned and will cause a delay in receiving your MCSR. Where photocopied licenses are to be submitted along with your application, do not send originals. They will not be returned.

For further information visit our Web site at <http://www.mass.gov/dph/dcp>

Application Type: (Please select one)

☐ New

☐ Renewal

☐ Amended Information

In the boxes below enter the requested information.

1)) Massachusetts Board of Registration License No.:

2)) Name:

First:

Middle:

Suffix: (e.g. Jr., Sr., II, III)

Last:

3)) Applicant Business Address:

Applications that include a P.O. Box number without a street address cannot be processed. Out-of-state addresses require a letter of explanation.

4)) Business Telephone No.:

()
area code

5)) Social Security No.: (Required by M.G.L. c. 30A, s. 13A)

6)) Have you ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substances? ☐ Yes * ☐ No

7)) Has any previous professional license or registration held by you under any name or corporate name or legal entity been surrendered, revoked, suspended or denied or is such action pending? ☐ Yes * ☐ No

* If you answered "Yes" to Question No. 6) or No. 7), a letter must be attached setting forth circumstances of such action(s).

I hereby certify that the information on this application is true to the best of my knowledge, and that I will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health. I also certify, in accordance with M.G.L. c. 62C, s. 49A, that I have to the best of my knowledge and belief filed all state tax returns and paid all state taxes required under law.

Signed under the pains and penalties of perjury.

Signature of applicant (no initials) _____

Date _____

For Office Use Only

Application approved by:

Comments:

Date: